Claims Clues

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ESP Recipients Require Dialysis Authorization

All dialysis services for Emergency Services Program (ESP) recipients must be included in an Extended Services Package established by the AHCCCS Prior Authorization Unit.

Non-emergency care and preventive care services, including vaccines for influenza, pneumonia and Hepatitis B, are not covered for ESP recipients. Only those services listed in the end stage renal disease (ESRD) Extended Services Package will be reimbursed by AHCCCS.

Providers may contact the PA Unit at:

- (602) 417-4400 (Phoenix area)
- 1-800-433-0425 (in state)
- 1-800-523-0231 (out of state)

The services in the ESRD Extended Services Package are defined by the AHCCCS Office of the Medical Director. Non-covered services billed by a hospital-based or freestanding dialysis facility will be denied. In some cases, billing such non-covered services may cause the entire claim to be denied.

The Admit Type field (Field 19) on the UB-92 claim form should be left blank. Dialysis facilities must not enter an Admit Type "1" (Emergency) when billing for dialysis services for ESP recipients. Entering a number in the Admit Type field may cause the claim to be reimbursed incorrectly or denied by the AHCCCS Claims Processing System, resulting in claim resubmissions and/or payment recoupments. ❒

AHCCCS Adopts Increased ESRD Facility Rates

The AHCCCS Administration has adopted Medicare's increased composite rates for dialysis services provided by end stage renal disease (ESRD) facilities.

The new rates, effective for dates of service on and after Jan. 1, 2000, apply only to freestanding ESRD facilities. Hospital-based dialysis facilities are reimbursed at the hospital's outpatient cost-to-charge ratio.

Related Stories, Pages 3 & 4

Because AHCCCS reimburses the lesser of the billed amount or the rate on file, providers must bill the new rate to be reimbursed the increased amount. If a provider bills a lesser amount than the established rate, AHCCCS will pay the lesser amount.

The table below shows the new composite rates for freestanding dialysis facilities.

Providers who have questions about these rates should call Claims Customer Service at (602) 417-7670 or toll-free at 1-800-654-8713 (in state) or 1-800-523-0231 (out-of-state). ❒

	Hemodialysis Per Trmt Rev Code 821	CAPD Per Day Rev Code 841	CCPD Per Day Rev Code 851	CAPD Training Rev Code 841	CCPD Training Rev Code 851
Metropolitan Phoenix	$129.10	$55.33	$55.33	$141.10	$149.10
Metropolitan Tucson	$125.02	$53.58	$53.58	$137.02	$145.02
Rural Arizona & Out-of-State	$119.52	$51.22	$51.22	$131.52	$139.52

Rate Schedule Published on New Web Site Page

The fee-for-service rate schedule is now available on the new Plans and Providers page on the AHCCCS Web site. The rates are effective June 1, 2000.

The AHCCCS Web site address is www.ahcccs.state.az.us.

Click on "Plans/Providers" on the navigation bar on the left side of the home page to go to the newly created page.

Click on "Procedure Codes and Rates" to display the rate schedule page. Rates are displayed by type of service, such as transportation, radiology, surgery, dental, etc.

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IHS Providers Must Meet Consent Form Requirements

Indian Health Services (IHS) providers must meet the same requirements as other AHCCCS providers in order to be reimbursed for abortion, hysterectomy, and sterilization services.

Sally K. Richardson, director of HCFA's Center for Medicaid and State Operations, said in a letter to the AHCCCS Administration that IHS providers must use "the proper consent/acknowledgement form which must be received and reviewed by the Medicaid agency for compliance with the applicable statutory or regulatory requirements before payment can be made."

AHCCCS requires a completed Federal Consent Form to be submitted with claims for all voluntary sterilization procedures. A copy of the signed form must be submitted by *each provider* involved with the procedure.

An AHCCCS Hysterectomy Consent Form must be submitted with all claims for hysterectomy services. Providers may use a hospital consent form that contains the same information as the Hysterectomy Consent Form.

AHCCCS covers abortions only when necessary to protect the mother's life or, for categorically eligible recipients, when the pregnancy is the result of rape or incest.

All abortions require prior authorization except in cases of medical emergency. The PA request must be accompanied by a Certificate of Necessity for Abortion.

In the event of an emergency, documentation of medical necessity must be provided to AHCCCS within two working days after the procedure was performed.

Chapter 5, Pages 5-25 and 5-31 of the *Native American Fee-For-Service Billing Manual* indicate that providers must keep the sterilization and hysterectomy consent forms in patient records but do not need to submit these forms with claims. Providers should update these pages to reflect the requirement to submit these forms with claims. ❒

AHCCCS Begins Workers' Compensation Recovery Program

The AHCCCS third party liability contractor, Public Consulting Group Inc. (PCG), recently completed the first data match with the Industrial Commission of Arizona to identify previously unknown Workers' Compensation information for AHCCCS recipients.

The recovery process is being conducted in the same manner as the AHCCCS Medicare Disallowance Recovery Program.

PCG has identified claims paid by AHCCCS that appear to be claims that would be covered by a Workers' Compensation carrier. PCG is sending notices to the identified providers this month requesting that they submit their claims to the Workers' Compensation carrier. PCG will include in the notice to the providers the Workers' Compensation Claim Number and the name and address of the identified Workers' Compensation carrier to whom the claims should be billed.

Providers will be given 150 days to provide PCG with an EOB or other acceptable documentation that verifies the Workers' Compensation carrier's payment or denial of payment. If documentation is not received by PCG within 150 days, AHCCCS will recoup the full amount of the original AHCCCS payment.

Because this is a new recovery program and this is the first notice to providers, providers will be granted additional time for billing the Workers' Compensation carrier when the situation warrants an extension.

Questions about the new recovery program should be directed to:

Christopher Connor
Public Consulting Group, Inc.
345 Magnolia Drive
Suite A-16
Tallahassee, FL 32301

He can be reached at 1-800-973-7828 or via email at cconnor@pcgus.com. ❒

Rate Schedule Published on New Web Site Page

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Providers also will find links that will allow thew to view newsletters, including *Claims Clues*, and manuals, including the *Fee-For Service Provider Manual* and the *AHCCCS Medical Policy Manual.*

The Plans and Providers page is under development, and certain features will not be immediately available. ❒

Many Lab Tests Included in ESRD Composite Rate

Several routine laboratory tests are covered and reimbursed in the composite rate paid to end stage renal disease (ESRD) facilities.

If an outside laboratory performs these tests at the specified frequencies, the lab must bill the dialysis facility. The dialysis facility is responsible for payment for these tests.

Non-routine laboratory tests for fee-for-service dialysis patients must be billed to the AHCCCS Administration on a HCFA 1500 claim form by Medicare-approved laboratories with the appropriate CLIA certification.

Medicare-approved ESRD dialysis facilities with a CLIA waiver may bill for waived tests not covered in the composite rate on the UB-92 claim form if there is medical justification indicating medical necessity.

The following tests are covered and reimbursed in the composite rate paid to dialysis facilities when performed in accordance with the specified frequencies.

Hemodialysis

- Per dialysis: All hematocrit or hemoglobin and clotting time tests furnished incident to dialysis treatments.
- Per week: Prothrombin time for patients on anticoagulant therapy, BUN, Serum Creatinine
- Per month: CBC, Serum Calcium, Serum Potassium, Serum Chloride, Serum Bicarbonate, Serum Phosphorous, Total Protein, Serum Albumin, Alkaline Phosphatase, Aspartate aminotransferase (AST, SGOT), LDH

CAPD

- Per month: BUN, Creatinine, Sodium, CO_2, Calcium, Magnesium, Alkaline Phosphatase, Phosphate, LDH, Potassium, Total Protein, Albumin, Aspartate aminotransferase (AST, SGOT), Hct, Hgb, Dialysate Protein

Laboratory tests other than those listed may be billed to AHCCCS. Routine tests performed and billed more frequently than listed and non-routine tests must include medical justification and the physician's order for the tests. ❐

Lab Documentation Requirements Revised, Clarified

The AHCCCS Administration has revised and clarified its documentation requirements for fee-for-service claims for laboratory services performed for dialysis patients.

AHCCCS began conducting prepayment reviews of these claims earlier this year. The documentation requirements were initially announced in the January issue of *Claims Clues*. These requirements have been revised and clarified as follows:

Results of the laboratory tests

Providers no longer are required to submit test results with the claim for lab services.

Physician's orders for tests

The order form/prescription the physician must submit to the lab ordering the tests must be submitted with each claim. If a copy of the order form is not submitted with the claim, it will be automatically denied without further review. The claim will not be reviewed for medical necessity until the orders are received.

AHCCCS does not create recipient history files. Orders for tests must be submitted with *each claim*, even if the order form for the test is submitted to the laboratory only once a year and the test is performed and billed monthly during the year.

Medical documentation demonstrating that the test is medically necessary

This documentation may consist of the ICD-9 diagnosis code indicated by the physician as the medical reason for ordering the test.

Providers should not submit claims for tests included in the dialysis composite rate. If the physician feels it is medically necessary to order an additional test that is covered in the composite rate, the claim must contain the diagnosis code that supports medical necessity. A diagnosis code of 585 (chronic renal failure) alone is not sufficient.

Ferritin and Aluminum may be performed and billed once every three months with a diagnosis code of 585 alone. Additional claims for Ferritin and Aluminum will be denied unless another ICD-9 diagnosis code justifying medical necessity is submitted with the claim.

In some instances, Medical Review staff may determine that the diagnosis codes do not provide valid justification for ordering tests. In these cases, the claim or individual tests may be denied with an edit message that requests additional documentation. ❐

Providers Must Bill Infed Code Based on DOS

Providers must ensure that they bill the correct HCPCS code when billing for Infed.

Providers should bill J1750, a new code established this year, on claims with a beginning date of service on or after Jan. 1, 2000.

Providers should bill the old code, J1760, when the ending date of service is prior to Jan. 1, 2000.

For example, if a claim is submitted for dates of service 10/02/1999 - 10/30/1999, the provider should bill using J1760. If J1750 is billed, the AHCCCS system will deny the claim because the beginning date of service is prior to Jan. 1, 2000. ❒

Electronic Claims Submission Hours Expanded

The hours during which providers may submit electronic claims to the AHCCCS Administration have been expanded to allow providers more opportunity to submit claims and to improve turnaround time.

AHCCCS accepts electronic claims transmissions between midnight and 6:00 p.m. Monday through Thursday and between midnight and 4:00 p.m. on Fridays.

Completed transmissions received by 4:00 p.m. on Friday generally will be considered for that weekend's payment cycle.

Prior to May 1, providers could submit claims between 6:00 a.m. and 6:00 p.m. Monday though Friday.

UB-92 and HCFA 1500 claims may be submitted electronically, regardless of the requirements for attachments (e.g., EOBs, medical documentation, etc.).

When a claim is received, the AHCCCS Claims System will determine if an attachment is required. If so, the system will generate a letter identifying the type of attachment needed to adjudicate the claim. Providers have 30 days to submit the required attachments.

For more information, contact the AHCCCS Electronic Claims Submission Unit at (602) 417-4242 or (602) 417-4706. ❒

Electronic Remittance Available to Electronic Filers Only

The AHCCCS Administration will provide electronic remittance advices only to those providers who submit fee-for-service claims electronically.

The electronic remittance advice will not be made available to providers who submit paper claims.

The remittance advice will be transmitted to providers via the Internet to the provider's email address. The remittance advice will be a file attachment to an email, and it will retain its current content.

Providers who select the electronic Remittance Advice will no longer receive a paper copy of the document.

Electronic transmission of the remittance advice does **not** include electronic deposit of reimbursement checks. Reimbursement checks will continue to be mailed to the provider's pay-to address.

A provider must complete an authorization form in order to receive the electronic remittance advice. The form must be signed by the provider or the provider's designated agent. The form is available by contacting the AHCCCS Provider Registration Unit at (602) 417-7670 (Option 5).

AHCCCS expects to make the electronic remittance advice available in August. ❒

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

Provider type 52 (MH clinic)

- End date 90889 effective 09/30/98

Provider type 72 (RBHA)

- End date W2020, W2150 - W2153, W2200, W2201, W2202, W2210, W2300, W2351 effective 09/30/98

Provider type 74 (Alternative residential facility)

- Open end W2050, W2300, W2350, W2351, Z3138, Z3140
- End date W2040 effective 01/31/00
- Add Z3139 effective 10/01/96

Provider type 77 (MH rehab)

- Open end W2100, W2400, W2402
- End date W2353 effective 06/30/99